BEFORE THE BOARD OF MEDICAL EXAMINERS
STATE OF MONTANA

IN THE MATTER OF DOCKET NO. CC-04-0093-MED REGARDING:

THE DISCIPLINARY TREATMENT OF	)	Case No. 2808-2004
THE LICENSE OF JAKE ALLEN, MD,	)	
License No. 6437.	)	

PROPOSED FINDINGS OF FACT; CONCLUSIONS OF LAW; AND RECOMMENDED ORDER

I. INTRODUCTION

Hearing Examiner Gregory L. Hanchett held a contested case hearing in this matter on January 4, 5 and 6, 2006. Gene Allison, agency legal counsel, represented the Business Standards Division (BSD). Dr. Allen represented himself. Dr. Allen, MD, Brock Wiegand, RN, Dr. David Rohrer, MD, Roger Beargeon, RN, Mary Toren, RN, Dr. Dan Alzheimer, David Arensmeyer, Daniel Arensmeyer, Jeanne Worsech, LaDonna Ladd, Leah Moroney, Natalie and Sara Steinmetz, Mr. Bawden, PhD., Sandra Ondler, RN, Grace Salyer, and Renee Russell all testified under oath. BSD Exhibits 1, 2 and 3 and Dr. Allens' Exhibits C, D, E, F, G, H, I , J, L, M, and N were admitted into evidence.

Prior to the beginning of the hearing, BSD moved to dismiss all allegations against Dr. Allen contained in the complaint except for the allegation related to the care of Robert Arensmeyer (identified in the complaint as Patient A). In addition, BSD proceeded solely on the allegations that Dr. Allen failed to conform to generally accepted standards of practice in violation of Montana Code Annotated 37-1-316(18) and engaged in conduct likely to deceive, defraud or harm the public in violation of Administrative Rule 24.156.625(3) by (1) undertaking the surgery on Mr. Arensmeyer, (2) failing to stop the operation upon discovering pervasive abdominal adhesions in Arensmeyer, (3) failing to take corrective action to stop patently obvious post-operative bleeding in Mr. Arensmeyer that eventually resulted in Arensmeyer's death, and (4) by failing to make proper arrangements for Arensmeyer's care prior to leaving Great Falls.

Pursuant to stipulation at the conclusion of the hearing, the parties were permitted to file post-hearing briefs. In conformity with this tribunal's post-hearing order, counsel for the BSD filed a timely brief. Dr. Allen failed to file any post-hearing brief and the record closed in this matter on May 12, 2006. Based on the evidence adduced at the hearing, the hearing examiner makes the following findings of fact, conclusions of law, and recommended order.

II. FINDINGS OF FACT

A. *Allen Operates On Arensmeyer*.

1. At all times pertinent to this case, Dr. Jake Allen has been a medical doctor licensed by the Montana Board of Medical Examiners (Board of Examiners).

2. In November, 2002, Dr. Allen's patient, Mr. Robert Arensmeyer, complained to Dr. Allen of claudication in the left leg (pain in Arensmeyer's leg after exercise). Dr. Allen had previously performed surgeries on Mr. Arensmeyer. *Transcript, Day 3, p. 109-110.* Mr. Arensmeyer had also undergone a bowel resection for colon cancer in 1967. *Transcript, Day 3, p. 117*.

3. The claudication did not prevent Mr. Arensmeyer from engaging in his regular life activities. *Transcript, Day 2, p. 163.* He was able to walk at least one half block before experiencing claudication. Moreover, Mr. Arensmeyer, who was retired from his profession of painting, lived by himself, maintained his household, drove his own vehicle, fished, and golfed regularly. *Transcript, Day 2, p. 160-163, 177-178.* Mr. Arensmeyer did not meet the definition of having 'disabling claudication'. *Transcript, Day 1, p. 338, 340.*

4. In response to Mr. Arensmeyer's complaint, Dr. Allen admitted him to Benefis Healthcare on January 6, 2003. *Exhibit 1, p. DLI 1921-1922, 1931 and Transcript, Day 3, p. 115.* On January 7, 2003, Dr. Allen performed an aorto-femoral bypass (ABF Bypass) graft on Mr. Arensmeyer. *Exhibit 1, Operation Report, p. DLI 1921-1922.* An ABF graft involves placing a synthetic graft from the patient's aorta down to the femoral arteries in both groins in order to bypass an occluded or stenosed artery. *Transcript, Day 1, p. 168-170.* The surgery was elective; i.e., it was not necessary to preserve either life or limb. *Transcript, Day 1, p. 337-339.*

5. Adhesions are scar tissue which may be caused by prior abdominal surgeries. *Transcript, Day 3, p. 130, 198-199.* Knowing that Mr. Arensmeyer had a history of a bowel surgery with resection, Dr. Allen should have expected there would be adhesions in Mr. Arensmeyer's abdomen. *Transcript, Day 3, p. 199-200.* Adhesions can be a reason for finding that a patient has a 'hostile abdomen'. *Transcript, Day 1, p. 341-342.* A hostile abdomen is a contraindication to the type of surgery performed on

Mr. Arensmeyer (ABF Bypass). *Exhibit K, p. 1464 and 1465-66.* Mr. Arensmeyer did have a 'hostile abdomen'. *Transcript, Day 1, p. 235, Day 3, p. 202.* A surgeon who finds extensive adhesions in the abdomen (i.e. a hostile abdomen) can stop the surgery and close the patient. *Transcript, Day 1, p. 342.* Just because a surgeon has made an incision in a patient does not mean that the surgeon cannot stop the operation. *Id.* Despite the number of adhesions that he encountered in Mr. Arensmeyer's abdomen, Dr. Allen did not stop the surgery.

6. During the surgery, Dr. Allen had to go "slower than usual" taking down (cutting apart) adhesions in the abdominal cavity. *Exhibit 1, Operation Report, p. DLI 1921-22.* He felt it was "very tedious", "very difficult". *Id.* He thought the adhesions "made the case much, much more difficult". *Id.* Dr. Allen cut adhesions off of the anterior wall, the pelvis, the left lateral wall, and the posterior wall of the abdomen. *Id.* Dr. Allen had some difficulty with bleeding of the lumbar veins in the retroperitoneal area. The lumbar veins bled just after he commenced the ABF and continued to 'ooze' over the period of the operation. *Id.* However, Dr. Allen stated that he controlled the bleeding with clips. Although "it was difficult to see", Dr. Allen thought that the clips "seemed" to take care of the problem. *Id.* Although Dr. Allen described the bleeding from the lumbar veins twice in his operation report, he did not describe the serosal surfaces of the abdomen or mention any problems with the serosal surfaces. *Id. and Transcript, Day 1, p. 305-308.* Mr. Arensmeyer lost approximately 1600 ccs of blood of which 900 ccs were collected and returned to him - a process known as 'Cellsaver'. *Exhibit 1, Operation Report, p. DLI 1964, 2076 and Transcript, Day 1, p. 165, 174, 360, 364.*

B. *Immediate Post-Op to 7:00 a.m. on January 8, 2003*

7. Following the surgery, Mr. Arensmeyer was transferred to the Cardiac Intensive Care Unit (CICU). *Transcript, Day 2, p. 8.* Mr. Arensmeyer initially seemed to do well post-op in CICU except for some hypertension. *Transcript, Day 1, p. 27-28.* Dr. Highfill, the consulting cardiologist, treated the hypertension. *Exhibit 1, p. DLI 1936 and Transcript, Day 1, p. 28-31.* However, throughout the late evening hours of January 7 and early morning hours of January 8, 2003, Mr. Arensmeyer's post-operative medical condition deteriorated noticeably. *Transcript, Day 1, p. 73, 89, 119, 123-124, 133-134, Transcript, Day 2, p. 13.*

8. Brock Wiegand and Roger Beargeon were the Registered Nurses (RN) who cared for Mr. Arensmeyer that night. *Transcript, Day 1, p. 18 and Transcript, Day 2, p. 8.* When a patient is critical, the nurses operate as a team for the critical patient with one nurse providing primary care and the other acting as back-up. *Transcript, Day 1, p. 18-19.* Nurse Wiegand was assigned as the primary care nurse for Mr. Arensmeyer while Nurse Beargeon acted as back-up for Nurse Wiegand. *Transcript, Day 1, p. 17-19 and Transcript, Day 2, p. 8.* There were three patients on

CICU that night but Nurse Wiegand's only duty was to provide care for Mr. Arensmeyer on a one-on-one basis. *Id. and Transcript, Day 1, p. 75-76.*

9. When Nurse Wiegand came on duty at 7:00 p.m. on January 7, 2003, Mr. Arensmeyer was alert and oriented. *Transcript, Day 1, p. 27.* Wiegand spoke with Dr. Highfill about Mr. Arensmeyer's heart rate or blood pressure problems which had mostly been addressed before he arrived. *Transcript, Day 1, p. 28-30.* Mr. Arensmeyer's vital signs were relatively stable. *Transcript, Day 1, p. 27.* It was noted that the instrument which was reporting the central venous pressure (CVP) was reading inaccurately. *Transcript, Day 1, p. 32-33.*

10. At the beginning of Nurse Wiegand's shift, Mr. Arensmeyer was not making sufficient urine. His urine output was less than 30 ccs per hour. *Exhibit 1, p. DLI 1985*. At approximately 8:00 p.m. on January 7, Nurse Wiegand called Dr. Allen and received telephone orders to administer saline if Mr. Arensmeyer's urine output was less than 80 ccs per hour. Nurse Wiegand was also to check the hemoglobin and hematocrit (H & H) and "transfuse" if the HCT was below 30. Dr. Allen's orders did not specify what to transfuse or how much to transfuse. The order also directed Nurse Wiegand to call Dr. Allen if the HCT was below 25. *Id. and Exhibit 1, p. DLI 1937, 1985 and Transcript, Day 1, p. 33*. It was at this time that Nurse Wiegand first noted in his Nurses Patient Progress Notes that the CVP instrument was not reading correctly. *Transcript, Day 1, p. 32-33 and Exhibit 1, p. DLI 1985*. At approximately 8:00 p.m. on January 7, Dr. Allen was notified of the inaccurate CVP reading. *Id. and Exhibit 1, p. DLI 2076.*

11. Hematocrit measures blood volume and can be a factor in determining whether bleeding is taking place. *Transcript, Day 1, p. 22*. A normal range for hematocrit is 42.6 to 51. *Id.* Prior to Mr. Arensmeyer's surgery, his hematocrit was 49.4. *Transcript, Day 1, p. 22 and Exhibit 1, p. DLI 1956.* At 3:56 in the afternoon, shortly after the surgery, the hematocrit was 35.3. *Id.*

12. Platelets are a substance in the blood which assists in clotting. Platelets are consumed in the process of blood clotting. *Transcript, Day 1, p. 23, 189-190.* A normal range for platelets is 146 to 360. *Transcript, Day 1, p. 189*. Mr. Arensmeyer's platelet count prior to surgery was 365. *Exhibit 1, p. DLI 1949.* Mr. Arensmeyer's platelet count at 3:56 on the afternoon of January 7 (just after the surgery) was 234. *Transcript, Day 1, p. 23 and Exhibit 1, p. DLI 1956.* Although numerous other tests were ordered and obtained, the platelets were not checked again until 7:58 on the morning of January 8. At that time the platelet level was 52. *Transcript, Day 1, p. 189 and Exhibit 1, p. DLI 1955.*

13. INR is also a factor in blood clotting. The higher the number is, the less the blood is able to clot. *Transcript, Day 1, p. 25-26.*

14. Creatinine is a measure of kidney (renal) function. *Transcript, Day 1, p. 23-24.* A normal range for creatinine is .06 to 1.3 mg/dl. *Exhibit 1, p. DLI 1957.* When the creatinine level rises outside the scale, it indicates a problem with kidney function (renal insufficiency). *Transcript, Day 1, p. 24, 86-87.* At 1.5, Mr. Arensmeyer's creatinine was just out of the normal range at 3:56 on the afternoon of January 7. *Transcript, Day 1, p. 23-24 and Exhibit 1, p. DLI 1957.* Throughout the night, it never went down. Instead it climbed steadily. *Exhibit 1, p. DLI 1957.*

15. Additionally, potassium levels can also be a marker of poor kidney function. Potassium is excreted through kidneys. If the kidneys aren't working well, the patient's potassium levels go up. *Transcript, Day 1, p. 131.* A high potassium level is known as 'hyperkalemia.' *Transcript, Day 1, p. 48*. Bleeding can lead to poor perfusion (hypoperfusion) of blood in peripheral tissues including the kidneys. Decreased tissue perfusion in the kidneys can lead to poor kidney function which results in hyperkalemia (high potassium levels). *Transcript, Day 1, p. 48, 189, 312-313.* Therefore, a high potassium level can be an indication of bleeding. A normal reference range for potassium is 3.5 to 5.1 MEQ/L. *Exhibit 1, p. DLI 1957.*

16. Metabolic acidosis is caused by something wrong in the metabolic system of the patient. *Transcript, Day 1, p. 90-91.* A patient is considered to be 'acidotic' (or to be experiencing 'acidosis') if the patient's PH level is less than 7.35. *Transcript, Day 1, p. 59 and Exhibit 1, p. DLI 1953.* A reference range for PH is 7.35 to 7.45. *Transcript, Day 1, p. 59 and Exhibit 1, p. DLI 1953.* Acidosis can be an indication of post-operative bleeding. *Transcript, Day 1, p. 163.* Administering bicarb or intubating a patient can assist in improving some kinds of acidosis. *Transcript, Day 1, p. 63, 92, 134, 328-329.*

17. Upon receipt of the results of Mr. Arensmeyer's 8:00 p.m. labs, Nurse Wiegand learned that the HCT had fallen to 30.6. *Transcript, Day 1, p. 175 and Exhibit 1, p. DLI 1955.* At 8:00 p.m., Dr. Allen provided a voice order to transfuse 2 units of packed red blood cells (PBRC). *Id.* The two units of PBRC as well as three units of saline were transfused commencing at approximately 8:30 and ending just after midnight. *Exhibit 1, p. DLI 1972, 1985.* If a patient is not bleeding, one would expect the transfusion of blood to cause the hematocrit and hemoglobin to remain stable or even to cause the hematocrit to rise a couple of points. *Transcript, Day 1, p. 41-45, 176-177 and Transcript, Day 2, p. 37-38.*

18. At approximately 11:00 p.m., Nurse Wiegand noticed that Mr. Arensmeyer's abdomen appeared to be getting larger. Therefore, Nurse Wiegand started measuring the circumference of the abdomen. *Transcript, Day 1, p. 36-37, and Exhibit 1, p. DLI 1976, 1985.* Also around 11:00 p.m., Mr. Arensmeyer's skin tone started to look mottled over his entire body. *Exhibit 1, p. DLI 1985 and* T*ranscript, Day 1, p. 49-50*. Mottling can relate to decreased tissue perfusion and PH balance. *Transcript, Day 1, p. 49.* Mr. Arensmeyer's urine output was still down and his blood

pressure was labile, fluid, and volume dependent. *Exhibit 1, p. DLI 1985 and Transcript, Day 1, p. 50*.

19. "Volume dependent" means that the patient's blood pressure is dependent on actually infusing blood or saline products into him. If the amount of products being infused is increased, the blood pressure goes up. If the amount is decreased or stopped, the blood pressure goes down. *Transcript, Day 1, p. 38-40*. In Mr. Arensmeyer's case, the blood pressure dropped during the short amount of time it took to change bags of blood products. *Transcript, Day 2, p. 15*. Standard practice in the CICU is to check the labs within a half hour after the completion of blood products infusion. *Transcript, Day 1, p. 45-46*. However, Nurse Wiegand felt there was something going on with Mr. Arensmeyer that needed to be investigated. He wanted to call Dr. Allen, so he decided to recheck the blood work early in order to have current information. *Transcript, Day 1, p. 50*. After midnight, Nurse Wiegand did blood draws for an arterial blood gas, BCS-7 covering potassium, sodium, blood sugar, etc., and an "H&H" test (hematocrit and hemoglobin). *Transcript, Day 1, p. 34, 50*.

20. A critical lab value is one which is far enough out of the normal range that it should be of concern to health care providers. Critical lab values are indicated on the written lab report with a highlighted black box around the numerical figure. If the lab determines that there is a critical value, the lab does not wait to provide the written results. The lab phones the nurse and lets the nurse know about the result. *Transcript, Day 1, p. 60-61 and Exhibit 1, p. DLI 1953.*

21. The results of Mr. Arensmeyer's midnight blood work came back at approximately 12:45 a.m. to 1:00 a.m. The results indicated that Mr. Arensmeyer was critically acidotic (abnormally high acidity/low PH). *Transcript, Day 1, p. 60 and Exhibit 1, p. DLI 1953.* Mr. Arensmeyer's blood work was less favorable than before with a PH balance of 7.189, a PCO2 of 28.7, a PO2 of 107.2, and a Bicarb level of 10.7. *Id. and Transcript, Day 1, p. 47-48.* Moreover, Mr. Arensmeyer's creatinine had risen to 2.0, his HCT had now further dropped to 24.2, and his potassium had risen from a normal value of 4.2 to a critical value of 7.1. *Transcript, Day 1, p. 46-48 and Exhibit 1, p. DLI 1955, 1957.* His abdomen also continued to swell. *Transcript, Day 1, p. 61 and Exhibit 1, p. DLI 1976-77.* At no time during the night did Mr. Arensmeyer's abdomen go down in size. *Transcript, Day 1, p. 37.* Instead, it grew from 101 cm at the time that Nurse Wiegand began measuring to 106.5 cm at 8:00 a.m. the following morning. *Exhibit 1, p. DLI 1976-1978.*

22. Nurse Wiegand called Dr. Allen with the results of the latest blood work. At approximately 1:15 a.m., Dr. Allen provided a telephone order for two units of PRBCs and four units of fresh frozen plasma (FFP). *Transcript, Day 1, p. 48-49 and Exhibit 1, p. DLI 1937, 1985.* Dr. Allen ordered that labs be run immediately after the infusion of the products. If the HCT at that time was less than 30, the nurse was to give 2 more units of PBRC and if the INR was less than 1.2, the nurse was to give 2 more units of

FFP. *Id.* The blood products were infused. *Transcript, Day 1, p. 58 and Exhibit 1, p. DLI 1969-71.*

23. At approximately 1:20 a.m., Dr. Allen provided a telephone order for bicarb in an effort to treat the acidosis. At 1:40, Dr. Allen provided a telephone order to treat the high potassium by discontinuing the potassium in the intravenous lines and by ordering insulin, calcium and saline followed by Lasix. *Transcript, Day 1, p. 50-54 and Exhibit 1, p. DLI 1938.* Lasix stimulates the kidneys to produce urine which will, in turn, help remove potassium from the patient's system. *Transcript, Day 1, p. 133.* Mr. Arensmeyer's urine output had been in fairly low numbers (20 to 30 ccs per hour). Nurse Wiegand administered the Lasix at 2:00 a.m. after which Mr. Arensmeyer produced 350 ccs between 2:00 and 3:00. *Transcript, Day 1, p. 54-57 and Exhibit 1, p. DLI 1976, 1993*. Thereafter, the urine output fell to lower numbers again. *Transcript, Day 1, p. 54-57 and Exhibit 1, p. DLI 1978.*

24. After 11:00 p.m. on January 7, Mr. Arensmeyer's general condition deteriorated. *Transcript, Day 1, p. 73.* His mental status dwindled. *Transcript, Day 1, p. 119.* Nurse Wiegand continued to administer PRBC and FFP per orders. Over the course of the night, Nurse Wiegand administered some 5 units of saline (totaling 4500 ccs) and 16 units of blood products (totaling 3900 ccs). *Transcript, Day 1, p. 72-73.* In fact, the patient was requiring so many blood products that Dr. Allen asked Nurse Wiegand to tell the lab to keep six units of PBRC ahead. *Transcript, Day 1, p. 53, Transcript, Day 3, p. 139 and Exhibit 1, p. DLI 1939.*

25. At midnight, Nurse Wiegand first recorded in the record that the patient was 'volume dependent'. *Transcript, Day 1, p. 38, 118 and Exhibit 1, p. DLI 1985.* That is to say that Mr. Arensmeyer's blood pressure was labile depending on the fluid status being infused. The pressure would go down when the rate of infusion was slowed or stopped and would rise when the rate of infusion was increased. Nurse Wiegand charted that Mr. Arensmeyer's systolic blood pressure was ranging from the 80s to the 170s depending on fluid status. *Id.* This information was relayed to Dr. Allen. *Transcript, Day 1, p. 74-75, 83, 84, 127 and Exhibit 1, p. DLI 1985.* Nurse Wiegand told Dr. Allen about the labs and his impression of Mr. Arensmeyer.

26. As a result of Nurse Wiegand's communications, Dr. Allen knew Mr. Arensmeyer was volume dependent. Dr. Allen also knew Mr. Arensmeyer was bleeding internally, but stated to Nurse Wiegand that he thought it was coagulopathy (an inability of the blood to clot or coagulate normally). When Nurse Wiegand told Dr. Allen that the abdomen had continued to swell, Dr. Allen replied, "That is where all of the blood and fluid is going, is into his abdomen". *Transcript, Day 1, p. 62, 93-95.* Nurse Wiegand expected that Dr. Allen would take the patient back to the operating room to fix the problem. *Transcript, Day 1, p. 71.*

27. Mr. Arensmeyer's blood work was rechecked again at approximately 3:45 a.m. on January 8. *Transcript, Day 1, p. 57 and Exhibit 1, p. DLI 1953, 1955, 1957.* The lab results continued to be poor and Mr. Arensmeyer's abdomen continued to get larger. The hematocrit had further dropped from 24.2 to 23.8. *Id. and Exhibit 1, p. DLI 1976, 1978.* The creatinine had further climbed from 2.0 to 2.1. *Transcript, Day 1, p. 57-58 and Exhibit 1, p. DLI 1957.* His PH level had further dropped from the already critical level of 7.189 to an even more critical level of 7.119. *Transcript, Day 1, p. 60 and Exhibit 1, p. DLI 1953.* Moreover, his potassium had dropped to 6.2. The treatments were administered to lower the potassium but, at 6.2, it was still at a critical level. *Transcript, Day 1, p. 132, 186 and Exhibit 1, p. DLI 1957 and 1985 (see nurse's entry for 0400 hours which states "K+ 6.2").* The nurse also noted in the record that the patient's systolic blood pressure was in the 80's. *Exhibit 1, p. DLI 1985*. Mr. Arensmeyer's mental and respiratory functions continued to deteriorate. *Transcript, Day 2, p. 13.*

28. After getting the 3:45 labs, Nurse Wiegand spoke to Dr. Allen. Nurse Wiegand relayed the results of the labs and also requested that the patient be intubated because the nurse felt that Mr. Arensmeyer might go into respiratory arrest at any time and because the nurse knew that intubation could help correct Mr. Arensmeyer's acidosis (PH level of 7.119). *Transcript, Day 1, p. 62-63, 96 and Exhibit 1, p. DLI 1953, 1985.*

29. At 4:30 a.m., Dr. Allen gave a telephone order for four more units of PRBC and four more units of FFP. He also ordered a liter of saline followed by more Lasix. Moreover, he ordered the patient to be intubated. Dr. Allen also told Nurse Wiegand that he (Allen) would call pulmonary. *Transcript, Day 1, p. 64-65 and Exhibit 1, p. DLI 1939.* Nurse Wiegand had the respiratory supervisor intubate Mr. Arensmeyer and set up a ventilator. He then waited for Dr. Blevins, the on-duty pulmonologist, to call. However, Dr. Blevins never arrived to see Mr. Arensmeyer. Nurse Wiegand thought Dr. Blevins must have been busy in the ICU and had not been able to respond to Dr. Allen's request. *Transcript, Day 1, p. 65.*

30. After these 4:30 telephone orders, Dr. Allen arrived at the CICU in person. This was the first time Dr. Allen had personally visited Mr. Arensmeyer since 8:00 p.m. on January 7, the previous evening. *Transcript, Day 2, p. 10, 19.* Dr. Allen's progress note for 5:00 that morning noted that Mr. Arensmeyer "was mottled & ABG showed metabolic acidosis" and the patient had now begun "clinically wearing out". *Exhibit 1, p. DLI 1944.* He also mentioned "believe patient's coagulopathy needed to be corrected". He stated that he would consult pulmonology and continue to correct the coagulopathy. He also noted that the "CVP was not working earlier in the night giving negative readings." *Exhibit 1, p. DLI 1945.*

31. At 4:58, Dr. Allen personally wrote more orders. In one he noted, "Consult Dr. Blevins for pulmonary management." *Exhibit 1, p. DLI 1939.* Nurse Wiegand asked Dr. Allen if he should notify Dr. Blevins (the pulmonologist) and Dr. Allen again told the

nurse that he (Allen) would call Dr. Blevins. *Transcript, Day 1, p. 64-65, 98 and Exhibit 1, p. DLI 1939.* Dr. Allen's signature affirming the previous telephone orders follows the nurse's written entry. In those orders, Dr. Allen clearly indicated he would call pulmonary. *Transcript, Day 1, p. 64-65 and Exhibit 1, p. DLI 1939.*

32. As a result of Dr. Allen's assurances that he would call pulmonary, Nurse Wiegand did not call Dr. Blevins. *Transcript, Day 1, p. 64-65*. At 4:58, Dr. Allen also wrote "consult nephrology on call at 7:30 for renal failure". *Transcript, Day 1, p. 66-67 and Exhibit 1, p. DLI 1939.* Despite clear indications of renal problems (reduced urine output, critical potassium levels, rising creatinine), Dr. Allen ordered that the nurses wait two and one half hours before consulting nephrology. *Id. and Transcript, Day 2, p. 34-35.*

33. At 4:30, Nurse Wiegand began infusing the blood products ordered by Dr. Allen over the telephone. The first unit of PRBC commenced infusion at 4:30 and finished at 4:40. The next unit was started at 5:00 and finished at 5:10. Nurse Wiegand then infused two units of FFP from 5:20 to 6:00. Two more units of PRBC were infused from 6:05 to 6:30 and two units of FFP were infused from 6:45 to 7:00. *Transcript, Day 1, p. 67-68 and Exhibit 1, p. DLI 1968, 1967, 1966, 1965.* After the last of these blood products were infused at 7:00, Nurse Wiegand had no further orders from Dr. Allen for blood products. *Transcript, Day 1, p. 67, 69, Transcript Day 2, p. 18, 50.* Throughout the infusion of these 8 units of blood products, Mr. Arensmeyer continued to be volume dependent. *Transcript, Day 1, p. 69 and Exhibit 1, p. DLI 1978.*

34. By this time, Mr. Arensmeyer had been intubated. Intubation causes the patient's PCO2 level to come down. PCO2 is an acid. Lowering an acid will necessarily help bring a patient's PH up out of the acidotic range. *Transcript, Day 2, p. 48-49, 155 and Exhibit 1, p. DLI 1953.* While the products were infusing, more blood gas labs were obtained. They came back at 4:55 a.m. Although the PH had come up a bit, the labs showed a still critical PH level of 7.160 despite having Mr. Arensmeyer on fairly high ventilator/respirator settings. *Transcript, Day 1, p. 370, Transcript, Day 2, p. 48-49, 155 and Exhibit 1, p. DLI 1953.*

35. Nurse Wiegand was due to go off shift at 7:00. The next shift nurse to take over Mr. Arensmeyer's care was Nurse Mary Toren. While Nurse Wiegand was briefing Nurse Toren on Arensmeyer's condition, Dr. Allen called CICU by telephone around 7:00. Because Nurse Wiegand was briefing Nurse Toren, Dr. Allen spoke to Nurse Roger Beargeon for an update on the patient. Nurse Beargeon gave Dr. Allen the update and specifically told him that Mr. Arensmeyer was still volume dependent and that his condition hadn't changed since Dr. Allen was on the floor at 4:48.

36. Nurse Beargeon did not tell Dr. Allen that Mr. Arensmeyer had improved. Nurse Beargeon did not believe that Mr. Arensmeyer had improved. Instead, Nurse Beargeon believed Mr. Arensmeyer's condition had declined throughout the night.

Transcript, Day 2, p. 12-14. Mr. Arensmeyer had experienced predictable short term responses to treatments administered during the night but, overall, Mr. Arensmeyer's condition had markedly and noticeably declined. *Transcript, Day 2, p. 12-17.*

37. Despite the fact that Arensmeyer was in critical condition (a fact which Dr. Allen admitted at hearing), Dr. Allen nonetheless decided to leave Great Falls to go to Shelby. Dr. Allen told Nurse Beargeon that he was going out of town to see patients and that Dr. Rohrer was covering for him. *Transcript, Day 2, p. 19.* On Wednesdays, Dr. Allen performs what he described as 'little cases' in Shelby. *Transcript, Day 2, p. 215 and Transcript, Day 3, p. 44.* He admits that there was no case in Shelby that was so urgent that he had to leave Mr. Arensmeyer, who Dr. Allen also admits was a critical patient. *Transcript, Day 2, p. 206, 215*.

38. At no time did Nurse Wiegand tell Dr. Allen that the patient was improving. Nurse Wiegand felt that Mr. Arensmeyer was "very critical". Nurse Wiegand also thought that everybody involved in Mr. Arensmeyer's care understood that Mr. Arensmeyer was very critical. *Transcript, Day 1, p. 73-75*.

C. January 8, 2003, 7:00 a.m. to Arensmeyer's Death

39. Nurse Toren arrived at the CICU at about 7:00 a.m. on January 8, 2003. She was assigned to attend to Mr. Arensmeyer. As indicated in Paragraph 35, Nurse Wiegand briefed her on Mr. Arensmeyer's condition. Nurse Toren paged the on-call nephrologist, Dr. Rosenbaum, pursuant to Dr. Allen's earlier order that nephrology be called at 7:30 for a consult on renal failure. Nurse Toren advised Dr. Rosenbaum of Mr. Arensmeyer's status as charted in the 8:30 a.m. patient progress notes. *Transcript, Day 2, p. 92-93 and Exhibit 1, p. DLI 1985.*

40. After the 4:30 a.m. blood products finished infusing at 7:00 a.m., either Nurse Wiegand or Mary Toren ordered more labwork on Mr. Arensmeyer. *Transcript, Day 1, p. 70, Transcript, Day 2, p. 48-49 and Exhibit 1, p. DLI 1955, 1953, 1957, 1959.* Nurse Weigand briefed Nurse Toren on Arensmeyer's condition until 7:30 a.m. Nurse Toren then reviewed the flow sheets and lab sheets and then went into the room to conduct a complete nursing assessment on Mr. Arensmeyer. *Transcript, Day 2, p. 39-40, 43-44.* Dr. Highfill, a cardiologist, accompanied Nurse Toren to the room. *Transcript, Day 2, p. 43.*

41. In her first notation in the patient progress notes, Nurse Toren charted that the CVP instrument was not reading correctly due to poor waveforms. *Transcript, Day 2, p. 43-45 and Exhibit 1, p. DLI 1985*. Despite the fact that she did not believe the instrument readings were accurate, she continued to chart them, as she is required to do, but she also charted that she did not believe it was an accurate number. *Transcript, Day 2, p. 72-75 and Exhibit 1, p. DLI 1985.* She also observed that Mr. Arensmeyer's groin area was terribly ecchymotic (bruised). *Transcript, Day 2, p. 44, 46, 51, 92 .*

42. After assessing Mr. Arensmeyer, Nurse Toren felt that he needed to go back to the operating room. *Transcript, Day 2, p. 42-43.* Nurse Toren asked Dr. Highfill if he would have better luck getting Dr. Allen to take the patient back to the operating room. Dr. Highfill advised Nurse Toren to get all the labs for Dr. Allen and to get Dr. Allen to take Mr. Arensmeyer back to the operating room. *Transcript, Day 2, p. 132-133.* Dr. Highfill told Nurse Toren to add a Troponin marker to the lab work and to have an echocardiogram done in order to determine if there had been any cardiac event. The results for both were normal or no significant cardiac findings. *Transcript, Day 2, p. 60-61 and Exhibit 1, p. DLI 1958, 2021.*

43. Nurse Toren wanted to have the results of the labs in order to express to Dr. Allen how serious the patient's condition seemed so that he would take Mr. Arensmeyer back to the operating room. *Transcript, Day 2, p. 42-43, 147-149.* The results of the lab work came back with various times on them (between 7:58 and 8:10). *Exhibit 1, p. DLI 1955, 1953, 1957, 1959.* However, Nurse Toren did not yet have all of the results of the lab work back when Dr. Allen called her at 8:20. *Transcript, Day 2, p. 42-43.* At that time, the only lab results that Nurse Toren had back was the critical value on the potassium and the blood gas results. *Transcript, Day 2, p. 46-47.*

44. Because the potassium was at a critical level, the lab, per procedure, had called Nurse Toren with the result rather than wait for the paperwork to find its way to her. *Transcript, Day 2, p. 47.* At that time, Nurse Toren had been informed that the potassium level had not continued to drop as they had hoped. Instead, it had again risen to 6.4 (from 6.2 at 3:45). *Transcript, Day 2, p. 47-48.* At 7.276, the PH had finally come out of the critical level (from 7.160 at 3:45). *Exhibit 1, p. DLI 1953.* However, Mr. Arensmeyer was still acidotic (below normal PH levels). *Transcript, Day 2, p. 48.* Nurse Toren attributed the slightly improved PH level to the fact that Mr. Arensmeyer had been on a ventilator and a respirator. Moreover, while Mr. Arensmeyer's bicarb levels had slightly improved, it was not as much as should have been expected given the fact that Mr. Arensmeyer had been given several ampoules of bicarb. *Transcript, Day 2, p. 48-49.*

45. During her conversation with Dr. Allen, Nurse Toren related the results of the only labs which had returned at that point. Dr. Allen said he thought the patient was getting better. Nurse Toren told him she did not think so and explained why she thought so. *Transcript, Day 2, p. 48-49, 51.* She told him again that the patient had eccymosis in his groin and was mottled, his abdomen was distended but he had a pulse in his foot. Dr. Allen then asked, "So you're telling me that the patient doesn't have a dead foot". Nurse Toren replied, "Yes, that's what I'm telling you. He does not have a dead foot but what is the source of the acidosis? Why is his potassium climbing and why is he acidotic?" Nurse Toren then asked Dr. Allen, "Could he have an ischemic bowel?" Dr. Allen replied, "Well, now that you mention it, that is a possibility so why don't you do mesenteric duplex." (sic) Nurse Toren replied "Okay. But can they do that as a portable because if I move this patient, he will code and die on me. There's no way I

can take him down to radiology. Is there something that can be done portable?" Dr. Allen said he thought it could be done portably so she (Nurse Toren) should call down and see if it could be done portably. *Transcript, Day 2, p. 48-49, 51, 92.* Nurse Toren would not have known and would not have been expected to know how to order a mesenteric duplex study. *Transcript, Day 2, p. 71.*

46. Nurse Toren told Dr. Allen that she was still waiting for the other lab results. Dr. Allen told her to "Call Dr. Rohrer with those values because he knows about this patient and he'll treat them." Dr. Allen then told Nurse Toren that he was on his way to Shelby and she would not be able to reach him. He then repeated, "I think the patient is doing better." Nurse Toren said, "You know, I don't think so . . . When I came into the unit, his blood pressure was in the one teens. By 7:30 it's 100. 8:00 it's 90's and we're now almost 8:30 and it's in low 90's. I have nothing to fix that. I have no blood products to give him. He's so mottled. I don't think he looks good. He is not looking good to me." *Transcript, Day 2, p. 49-50, 51.* Dr. Allen gave no orders for additional blood products. *Transcript, Day 2, p. 50 and Exhibit 1, p. DLI 1942.*

47. Nurse Toren got off the phone with Dr. Allen and tried to schedule the mesenteric duplex study. When Nurse Toren called the lab, she found out there is no ability to do a portable mesentery duplex study. *Transcript, Day 2, p. 52.* When she found this out, she paged Dr. Rohrer. *Transcript, Day 2, p. 57.* Dr. Blevins had also been paged. *Transcript, Day 2, p. 53.*

48. Because Mr. Arensmeyer's blood pressure was continuing to drop, Nurse Toren prepared a bag of Dopamine. Dopamine is a treatment for hypotension (low blood pressure). *Transcript, Day 2, p. 52-53.* As she was preparing the Dopamine, Dr. Blevins called in answer to his page. Dr. Blevins was somewhat upset that he had not been notified of Mr. Arensmeyer's situation. Nurse Toren told Dr. Blevins if he did not do something Mr. Arensmeyer was going to "code". *Transcript, Day 2, p. 53-54*. Nurse Toren informed Dr. Blevins that she was going to start the Dopamine. *Transcript, Day 2, p. 52-54.*

49. At 7:30 a.m., Mr. Arensmeyer's systolic blood pressure had been 110. At 8:00 a.m., it was 100 and by about 8:15 it had dropped into the 90's. When she was speaking to Dr. Allen on the telephone, it was in the low 90's. Dr. Allen was told about the blood pressure issues. *Transcript, Day 2, p. 49-50, 54-55 and Exhibit 1, p. DLI 1978-1980.* At this time, Mr. Arensmeyer had normal saline infusing at full open. *Transcript, Day 2, p. 62, 84, 85, 90-91, 105 and Exhibit 1, p. DLI 1978-1980.* However, Nurse Toren had no further orders for blood products. *Transcript, Day 2, p. 50.*

50. Dr. Rohrer called Nurse Toren in answer to the page. Contrary to Dr. Allen's instruction to the nurses that Dr. Rohrer was covering for him, Dr. Rohrer was not on call that day. In fact, he was preparing to do a surgery. *Transcript, Day 1, p. 150-151, 194-195 and Transcript, Day 3, p. 220.* When she spoke to Dr. Rohrer,

Nurse Toren started to talk about Mr. Arensmeyer saying she was starting the Dopamine. Dr. Rohrer immediately stopped her and told her that until thirty seconds ago he had never heard of Mr. Arensmeyer and she would have to tell him what had happened. *Transcript, Day 2, p. 57.*

51. Nurse Toren then gave Dr. Rohrer a quick history on Mr. Arensmeyer including what had happened through the night, the blood products that had been given, and all pertinent lab values including the acidosis, the climbing creatinine, the climbing potassium, the low urine output, the abdominal girth, the hematocrit, the hemoglobin, and the mottled appearance. She also related that the blood pressure was continuing to fall and that there was the question of an ischemic bowel but that she could not move Mr. Arensmeyer to have a duplex performed because she feared he would die. Dr. Rohrer said if Mr. Arensmeyer does have an ischemic bowel, "there's really nothing I can do for him, just support his blood pressure." *Transcript, Day 2, p. 57*-58. The call ended.

52. Nurse Toren received the rest of the lab results and the other coagulapathy studies. *Transcript, Day 2, p. 58-59.* When she got the results, she again paged Dr. Rohrer. However, she no sooner had paged him than he personally appeared in the CICU. *Transcript, Day 2, p. 59.*

53. At about the same time, Dr. Highfill arrived in the CICU and all three went to Mr. Arensmeyer's room. Upon seeing Mr. Arensmeyer, Dr. Rohrer's immediate response was, "Oh, my God." *Transcript, Day 2, p. 59-60.* To Dr. Rohrer, it was "pretty obvious that [Mr. Arensmeyer] was going to die". *Transcript, Day 1, p. 151, 355, 356.* The decision was made 'fairly instantly' to take Mr. Arensmeyer back to surgery regardless of whether the problem was ischemic bowel or bleeding. *Transcript, Day 1, p. 151-152, 355.* Dr. Rohrer left to make the arrangements. *Transcript, Day 2, p. 60.* Dr. Highfill ordered Levophed which is a vasoconstrictor used to raise blood pressure. Nurse Toren went to get the Levophed. *Transcript, Day 2, p. 60, 62.* When she returned to Mr. Arensmeyer's room, his blood pressure was now in the 50's. *Transcript, Day 2, p. 62 and Exhibit 1, p. DLI 1978.* At this time, Nurse Toren began performing chest compressions because Mr. Arensmeyer was not responding. She and Dr. Highfill also administered bicarb, calcium, and epinephrine in an attempt to re-establish Mr. Arensmeyer's heart rhythm. *Transcript, Day 1, p. 158, Transcript, Day 2, p. 62-63 and Exhibit 1, p. DLI 1946.*

54. Dr. Rohrer was unable to find an open operating room so he brought a "crash cart" in order to perform the surgery at Mr. Arensmeyer's bed. *Transcript, Day 1, p. 152-153, Exhibit 1, p. DLI 1919 and Exhibit 2.* By the time Dr. Rohrer got back with the cart, Mr. Arensmeyer had already coded and the staff were attempting to resuscitate him. *Transcript, Day 1, p. 153.* Mr. Arensmeyer had no blood pressure at that time. *Id.* While Nurse Toren continued to perform chest compressions, Dr. Rohrer opened Mr.

Arensmeyer's abdomen. *Transcript, Day 1, p. 64, 154, Exhibit 1, p. DLI 1919 and Exhibit 2.*

55. Upon opening Mr. Arensmeyer's abdomen, there was a release of a large amount of old clot and blood as well as a large amount of fresh clot. The release of the blood filled up the bed resulting in a pool 1 and ½ inches deep from Mr. Arensmeyer's armpits to his knees. *Transcript, Day 1, p. 64, 154 and Exhibit 1, p. DLI 1946.* An ischemic bowel (lacking in blood supply) would look dark or black. *Transcript, Day 1, p. 64, 154-155, Exhibit 1, p. DLI 1919 and Exhibit 2.* Although it was edematous (swollen), the bowel did not appear to be ischemic. Dr. Rohrer started taking blood out of the abdominal cavity by the double-handfuls. *Transcript, Day 1, p. 64, 154, 159-160.* Dr. Rohrer reached in and digitally clamped Mr. Arensmeyer's aorta (pinched it with his fingers). Because Mr. Arensmeyer had no blood pressure at all, the aorta was flaccid even when the compressions were being done. If there were adequate blood supply in the aorta, Dr. Rohrer should have been able to feel a surge in it when the compressions were being performed. *Transcript, Day 1, p. 156-157, Exhibit 1, p. DLI 1919 and Exhibit 2.*

56. Despite the emergency action, Mr. Arensmeyer passed away in his room at 9:07 a.m. *Transcript, Day 2, p. 66 and Exhibit 1, p. DLI 2024.* At that time, Dr. Highfill listed the probable cause[s] of death as: Exsanguination post-op (bleeding out), metabolic acidosis, and hypovolemia (a decrease in the volume of circulating blood). *Transcript, Day 2, p. 158 and Exhibit 1, p. DLI 1946.*

57. After Mr. Arensmeyer died, Nurse Toren paged Dr. Allen to let him know Mr. Arensmeyer had passed away. *Transcript, Day 2, p. 66*. When she spoke to him, she told him the sequence of events up to Mr. Arensmeyer's death. Dr. Allen told her that he thought the cause of death was a cardiac event. Nurse Toren told him about the results of the troponin and the echocardiogram which did not indicate a cardiac event. *Transcript, Day 2, p. 67*. She told him that Mr. Arensmeyer's blood pressure had continued to fall after their previous conversation. She did not tell Dr. Allen that the patient had "suddenly deteriorated and died". *Id.* Nor did she ever tell Dr. Allen that Mr. Arensmeyer was improving or that he had stabilized. *Transcript, Day 2, p. 68*.

58. After Mr. Arensmeyer died, the hospital chaplain called Mr. Arensmeyer's son and daughter, David Arensmeyer and Barbara Mahn, to ask that the family come to the hospital. *Transcript, Day 2, p. 169*. By afternoon, Dr. Allen had returned from Shelby and spoke to the family in a waiting room of the hospital. *Transcript, Day 2, p. 171*, 178. He expressed his sorrow and then told them that Mr. Arensmeyer had a heart attack. He also said that they had re-opened Mr. Arensmeyer's abdomen and found no fresh blood in him. *Transcript, Day 2, p. 171, 178, 180.*

59. Dr. Allen stated the cause of death as an absolute. He did not qualify his statement that Mr. Arensmeyer had a heart attack. The family continued to believe that

their father had died of a heart attack until the Great Falls Tribune printed a story about Dr. Allen being suspended from Benefis Hospital due to the care he provided to Mr. Arensmeyer. *Transcript, Day 2, p. 172-173, 179.* Dr. Allen never called the family and corrected his statement about Mr. Arensmeyer's cause of death. *Transcript, Day 2, p. 173 and Transcript, Day 3, p. 194.* Dr. Allen did not advise the family to have an autopsy performed on Mr. Arensmeyer. *Transcript, Day 2, p. 174-175, 180.* Instead, the chaplain told the family that Mr. Arensmeyer needed to be autopsied because he had passed away within 24 hours of surgery. *Transcript, Day 2, p. 176.*

D. *The Expert Medical Testimony Establishes That Allen Fell Below the Standard Of Care.*

60. Dr. David Rohrer has been a practicing surgeon since 1991. He went to medical school at Creighton University graduating in 1986. He did his surgical training at Rush-Presbyterian in Chicago. He graduated from school with honors.

61. Dr. Rohrer worked for the United States Army for 4 and ½ years in a scholarship program - mainly at Moncrief Army Hospital in South Carolina but also in rotations to Honduras and Germany. He came to Great Falls after he completed his military duty in 1995 and has been in Great Falls since then. He has been vice-chair of surgery, chair of surgery, president of the Preferred Provider Organization, as well as the Independent Physicians Association since its inception 8 years ago. He has served on numerous committees and has been the medical director of outpatient services at Benefis West. He has been an instructor at Rush College and instructed laproscopic surgery at Moncrief. He is a member of the American Society of Bariatric Surgeons, the American Society of General Surgeons, the Northern Plains Vascular Surgical Society (for which he is also the secretary-treasurer), and the Rush Surgical Society. He is also a past member of the Montana Association of Cascade and Alpha Omega Honor Society.

62. Dr. Rohrer has performed over 10,000 surgeries including vascular surgeries. In the last five years he has focused his practice on bariatric surgeries but he still has hospital privileges and does all kinds of surgeries including vascular surgeries. He is aware of the standards of care for surgeons in general and vascular surgeons. He has performed peripheral vascular surgeries involving the infradiaphragmatic aorta peripheral to the legs and/or carotids, as well as vascular access procedures and exposures for the retroperitoneal for the back (also considered a vascular surgery).

63. Dr. Rohrer is familiar with the surgery that was performed on Mr. Arensmeyer on January 7, 2003. *Transcript, Day 1, p. 140-148.* Dr. Rohrer is familiar with the complications that can arise from ABF surgery. *Transcript, Day 1, p. 162-163.* Dr. Rohrer recognizes the symptoms of post-operative bleeding. Those symptoms include a combination of things including decreased blood pressure, increased pulse, decreased urine output, hypoglycemic shock, acidosis, and renal failure. *Transcript, Day 1, p. 162-163.*

64. Dr. Rohrer was qualified as an expert witness in this case. *Transcript, Day 1, p. 148.* Indeed, Dr. Allen's own witness, Sandra Ondler, who is a registered nurse (and also Dr. Allen's sister) with a specialty certification as an operating room nurse, described Dr. Rohrer as a "top-notch" surgeon. *Transcript, Day 3, p. 21.*

65. Dr. Rohrer reviewed the medical record for Mr. Arensmeyer's care at Benefis from January 6, 2003 to January 8, 2003. *Transcript, Day 1, p. 163-164.* After reviewing the medical records, it was Dr. Rohrer's opinion that the indications for this kind of surgery were not present. The stated complaint in this case was claudication. According to the recognized authority on this matter, Rutherford's *Vascular Surgery*, the clear indications for this type of surgery is rest pain (pain in the leg while at rest) and ischemia. *Transcript, Day 1, p. 199-200, 243-244,* and *Vascular Surgery,* (6th Ed) p. 770-772. Claudication (pain on exercise), which is what Mr. Arensmeyer had, is not, by itself, an indication for this surgery unless the claudication is disabling. *Transcript, Day 1, p. 199-200, 340 and Exhibit K.* Mr. Arensmeyer did not have a job-threatening or limb-threatening disease. He did not have ulcers in his leg. He did not have gangrene. He did not have pain at rest. He was not disabled. All he had was pain upon exercise for which other options were available. *Transcript, Day 1, p. 337-338.*

66. The mere fact that a patient wants an operation does not mean that the surgeon must do the operation. *Transcript, Day 1, p. 338-339.* The standard of care would have precluded operating on Mr. Arensmeyer at that time without first undertaking more conservative approaches such as lifestyle changes (i.e., requiring Arensmeyer to quit smoking) and attempting other treatments (stenting followed by revascularization of the left leg if the stenting was not adequate). *Transcript, Day 1, p. 200-202, 207, 210-211, 230, 237, 244-245, 337-338*.

67. As demonstrated by Dr. Rohrer's testimony, Dr. Allen's decision to perform an ABF Bypass on Mr. Arensmeyer fell below the required standard of care. *Transcript, Day 1, p. 199-200, 230, 247, 249-250*. Indeed, Dr. Allen essentially conceded at hearing that Dr. Rohrer had discussed a case similar to Mr. Arensmeyer's with the other members of the Northern Plains Vascular Surgical Society asking who would have operated on a patient like this. None of the members of the society would have recommended this operation in this scenario. *Transcript, Day 1, p. 208-209.* Dr. Rutherford himself was at the meeting. *Transcript, Day 1, p. 247-248.*

68. At hearing, Dr. Allen attempted to establish that this operation on Mr. Arensmeyer was appropriate by referring to an algorithm for aortic or bilateral iliac occlusive disease. *Transcript, Day 1, p. 218-219, 225-226 and Exhibit K. p. 1463.* However, that algorithm is only for someone with isolated aorta iliac disease rather than peripheral disease. *Transcript, Day 1, p. 229.* For a patient with claudication whose symptoms can be attributed to isolated proximal flow disease (as opposed to more distal disease), surgical intervention like an aorta iliac bypass might be appropriate.

Transcript, Day 1, p. 243, 244-245, 246-247. However, Mr. Arensmeyer had significant distal disease of the superficial femoral arteries (SFA). The left artery had more decreased blood flow than the right. *Transcript, Day 1, p. 169, 208, 224, 225, 229, 239, 243,* 246. Therefore, the algorithm presented by Dr. Allen was inappropriate for Mr. Arensmeyer's care. *Transcript, Day 1, p. 224, 225, 229, 241-242, 243, 246-247.*

69. The correct algorithm is the one on page 1463 of Exhibit K. Dr. Rutherford's algorithm at Figure 1 indicates that if a patient had neither disabling claudication or critical ischemia, no intervention was indicated. *Exhibit K, p. 1463.* Indeed, Dr. Allen himself conceded that in the absence of disabling claudication, the type of operation performed on Mr. Arensmeyer would be contraindicated. *Transcript, Day 3, p. 201, ll. 19-22*. Dr. Rohrer stated that Mr. Arensmeyer had neither disabling claudication or critical ischemia. *Transcript, Day 1, p. 340*. Mr. Arensmeyer also had none of the other indications for ABF intervention including "blue toe". *Transcript, Day 1, p. 340*. Therefore, performing an ABF on Mr. Arensmeyer at this time was below the standard of care.

70. However, even if one assumed that Mr. Arensmeyer had critical ischemia or disabling claudication, the correct algorithm would cause the surgeon to forego ABF in favor of balloon dilation (stenting). *Transcript, Day 3, p. 201-202*. Dr. Allen should not have performed this operation on Mr. Arensmeyer at this time.

71. As the expert testimony established in this case (and the hearing examiner so finds), when a patient has a hostile abdomen, an operation such as the one performed on Mr. Arensmeyer is contraindicated (should not be performed). *Transcript, Day 1, p. 341 and Exhibit K, p. 1464-1466.* Adhesions can be a reason for finding that a patient has a 'hostile abdomen'. *Transcript, Day 1, p. 341-342.* Dr. Allen conceded that it would have been reasonable to expect that Mr. Arensmeyer would have adhesions. *Transcript, Day 3, p. 199*-200. In fact, Dr. Allen said that one "almost always" sees adhesions if the patient has had abdominal surgery. *Transcript, Day 3, p. 199*. Dr. Allen also conceded at hearing that Mr. Arensmeyer had a hostile abdomen. *Transcript, Day 3, p. 202.* Mr. Arensmeyer did, in fact, have adhesions amounting to a hostile abdomen although it may not have been apparent before commencement of the operation. *Transcript, Day 1, p. 235, 341, Day 3, p. 202.* A surgeon acting within the scope of reasonably prudent practice who opens a patient's abdomen in this circumstance and discovers a hostile abdomen should simply close the incision. *Transcript, Day 1, p. 341*.

72. Dr. Allen's Operative Report for Mr. Arensmeyer twice mentions that he had trouble with bleeding from the lumbar veins. Apparently, it started early in the operation (after the lysis of adhesions) and continued to 'ooze' throughout the operation. *Exhibit 1, Operation Report, p. DLI 1921-22*. Dr. Allen stated that he controlled the bleeding with clips. Although "it was difficult to see", Dr. Allen thought that the clips "seemed" to take care of the problem. *Id.* Although he described the bleeding from the

lumbar veins twice in his operation report, he did not describe the serosal surfaces of the abdomen or mention any problems with the serosal surfaces. *Id. and Transcript, Day 1, p. 305-308.* Mr. Arensmeyer lost approximately 1600 ccs of blood of which 900 ccs were collected and returned to him - a process known as 'Cellsaver'. *Exhibit 1, Operation Report, p. DLI 1964, 2076 and Transcript, Day 1, p. 165, 174, 360, 364.* Dr. Rohrer believed this was 'significant' blood loss. *Transcript, Day 1, p. 165, 307.*

73. Mr. Arensmeyer had a preoperative HCT reading of 49. *Transcript, Day 1, p. 175 and Exhibit 1, p. 1956.* Although the initial post-operative HCT reading of 35.3 should not have caused too much concern, the one a few hours later (at 8:30 p.m.) which had dropped to 30.6 would have been more concerning although not alarming if there were no other indications of bleeding. *Transcript, Day 1, p. 175-176 and Exhibit 1, p. 1955.* Mr. Arensmeyer was given two units of PBRC at that point.

74. At 11:00, the nurse noted the swelling abdomen and the mottling which indicates hypoperfusion. Moreover, Mr. Arensmeyer's blood pressure was labile and fluid dependent and his urine output had dropped significantly. *Transcript, Day 1, p. 178.* At this point, Dr. Allen should have known the bleeding was significant. *Transcript, Day 1, p. 178.*

75. Mr. Arensmeyer's HCT continued to drop after midnight going down to 24.2. At the same time, his creatinine had risen from 1.5 to 2.0 and his potassium had gone up to a now-critical 7.1. *Transcript, Day 1, p. 178 and Exhibit 1, p. 1955, 1957.* The coagulopathy results were not so far out of normal to account for all of the bleeding in Mr. Arensmeyer's case. It was something more than a coagulopathy. *Transcript, Day 1, p. 183-185, 186-187, 333.* If Mr. Arensmeyer were going to bleed from the lysis of adhesions, it should have been most notable during the operation because that was when his blood was the most anti-coagulated. *Transcript, Day 1, p. 357-359.* The fact that Dr. Allen did not mention bleeding from the lysis of adhesions in his operative report indicates that they were not a concern at that time. *Transcript, Day 1, p. 357-359, 362.* If it were significant, it should have been in the operative report. *Transcript, Day 1, p. 363.*

76. After the 12:45 a.m. blood test results, Dr. Allen should have known at this point that there was ongoing bleeding that would require surgery. *Transcript, Day 1, p. 180, 182.* This was "a significant bleed" for which a reasonable surgeon should have been very concerned - especially knowing that there had been a retroperitoneal bleeding problem during the surgery. *Transcript, Day 1, p. 185*-186, 307-308. A reasonable surgeon should also have known that the eccymosis of Mr. Arensmeyer's penis, testicles, and groin area were as a result of ongoing retroperitoneal bleeding (from the lumbar veins) rather than from a coagulopathy of the serosal surfaces related to lysis of adhesions. *Transcript, Day 1, p. 203, 205-206, 311-312, 320-321, 357-358.*

77. Apparently, bleeding *was* on Dr. Allen's mind since after 1:00 a.m. He ordered two units of PRBCs and four units of fresh frozen plasma (FFP). *Transcript, Day 1, p. 48-49 and Exhibit 1, p. DLI 1937, 1985.* Dr. Allen also ordered that labs be run immediately after the infusion of the products and, depending on the results, the nurse was to give 2 more units of PBRC and 2 more units of FFP. *Id.* The blood products were infused. *Transcript, Day 1, p. 58 and Exhibit 1, p. DLI 1969-71.* Blood is not given for anything other than bleeding. *Transcript, Day 1, p. 320.*

78. Dr. Allen failed inexplicably to realize how sick Mr. Arensmeyer was. *Transcript, Day 2, p. 220.* The amount of blood products and fluids infused into Mr. Arensmeyer far exceeded his body's blood volume. *Transcript, Day 1, p. 191.* Mr. Arensmeyer had received a massive transfusion of blood products. *Transcript, Day 1, p. 190.* After such aggressive treatment, more improvement should have been reflected in the results of the 3:45 a.m. blood tests if the bleeding had been stopped. The fact that there wasn't a higher increase in the HCT should have told Dr. Allen that the bleeding had not stopped. *Transcript, Day 1, p. 186-188.* It was clear that there was an ongoing bleeding problem with Mr. Arensmeyer (as opposed to a coagulopathy). *Transcript, Day 1, p. 211-212, 218.* The old clot, fresh clot, and blood in his abdomen clearly indicated he had been bleeding for some time. *Transcript, Day 1, p. 159-161, 335-337, 224-225.* He did not 'suddenly' decline and die. *Transcript, Day 1, p. 320-321, 326-327, 328.* The standard of care for the post- operative period would have required that Mr. Arensmeyer be re-explored even before the 3:45 a.m. blood test results in order to discern the source of the apparent bleeding. He certainly should have been returned to the operating room after the 3:45 a.m. results were received. *Transcript, Day 1, p. 188 207, 210-211, 213.*

79. The standard of care for signing out to a covering physician requires that the primary physician (the physician who is leaving) have at least a verbal contact with the covering physician and tell him or her about any concerns that they may have with regard to a particular patient and to also let the covering physician know how long the primary physician expects to be gone. This is especially true of a critical patient like Mr. Arensmeyer. *Transcript, Day 1, p. 195, 344-345, 346-347.*

80. Dr. Rohrer, Dr. Allen and a Dr. McGregor shared call (patient coverage) pursuant to a written call schedule. *Transcript, Day 1, p. 197 and Exhibits C, D & E.* However, there was never any agreement that Dr. Rohrer would automatically assume care of Dr. Allen's patients during Dr. Allen's absence. *Transcript, Day 1, p. 197, 348-351.* "Signing out" is not the same as being "on-call". A call schedule is a written schedule so that the emergency room knows that there is someone they can call if needed. It is not a list for automatic coverage of a primary physician's patients. *Transcript, Day 1, p. 197, 270-272, 273-274*, 284, 344, 348-350. On the occasions when Dr. Rohrer has covered for Dr. Allen, Dr. Allen informed Dr. Rohrer about the patients and his plans to be absent. *Id.* Dr. Rohrer and Dr. Allen only 'covered' for each other when one had signed-out to the other. *Transcript, Day 1, p. 197, 344-345.* A

primary physician is always responsible for his patients unless he signs out to a covering physician. *Transcript, Day 1, p. 197*.

81. Dr. Allen did not note in the medical chart that he was signing out to Dr. Rohrer. *Transcript, Day 2, p. 205-206.* He admits that he did not talk to Dr. Rohrer about this admittedly critical patient. *Transcript, Day 2, p. 206.* Allen knew that it would have been important to get in touch with the covering physician to tell him what was going on with the patient, what had been attempted, how the patient had responded and to make some recommendations about the treatment. *Id.* Indeed, Dr. Allen at hearing conceded that he should have called Rohrer about Arensmeyer but he failed to do so. *Transcript, Day 3, p. 150, lines 13-15.* Rohrer had no actual knowledge of this patient. *Transcript, Day 2, p. 206-207.* Dr. Allen's own witnesses believed that he should have called Dr. Rohrer because sign-out requires a direct communication with the covering physician. *Transcript, Day 2, p. 253-255, Day 3, p. 225.* It was a concern to them that Dr. Allen did not speak to the physician covering for a critical patient. *Transcript, Day 2, p. 256, Day 3, p. 225.* Dr. Rohrer was not on-call on the day that Dr. Allen went to Shelby. *Transcript, Day 3, p. 220.* In retrospect, Dr. Allen admits he should have called Dr. Rohrer. *Transcript, Day 2, p. 207 and Transcript, Day 3, p. 150, 214.*

82. Dr. Allen was quite obviously psychologically affected by his inadequate treatment of Mr. Arensmeyer and Mr. Arensmeyer's death. Dr. Allen himself conceded that after Arensmeyer's death he became "increasingly depressed." *Transcript, Day 3, p. 155, lines 2-4.*

83. Dr. Allen has since discontinued his practice of medicine. He has begun a new career path and is presently enrolled in law school. *Transcript, Day 3, p. 156, lines 1-9.* His efforts to broaden his horizons are commendable. However, the fact that he has discontinued his medical practice necessitates placing a requirement upon his probation that his term of license probation and the term of his Montana Physicians Assistance Program (MPAP) contract be tolled (shall not run and shall not count toward the fulfilment of the MPAP requirement or the probation requirement of these recommended sanctions) during such time as he is not practicing medicine. It is only while he is actively practicing medicine that he will recognize the salutary effects that his license probation and MPAP contract will bestow upon him. Furthermore, it is only while he is actively practicing medicine that the health, safety and welfare of the public can be adequately protected.

III. CONCLUSIONS OF LAW[1]

A. *Allen Committed Acts of Unprofessional Conduct.*

[1] Statements of fact in the conclusions of laws are incorporated by reference to supplement the findings of fact. *Coffman v. Niece* (1940), 110 Mont. 541, 105 P.2d 661.

1. Mont. Code Ann. § 37-1-316 provides in pertinent part:

> The following is unprofessional conduct for a licensee . . . governed by this chapter:
>
> * * *
>
> (18) conduct that does not meet the generally accepted standards of practice.

2. Admin. R. Mont. 24.156.625(c) provides that unprofessional conduct includes any conduct likely to deceive, defraud or harm the public.

3. The department bears the burden of proof in this matter to demonstrate by a preponderance of the evidence that Dr. Allen committed an act of unprofessional conduct. Mont. Code Ann. § 37-3-311; *Ulrich v. State ex rel. Board of Funeral Service* (1998), 289 Mt. 407, 961 P.2d 126.

4. A plaintiff usually must produce "expert medical testimony regarding the applicable standard of care and departure from that standard." *Estate of Nielsen v. Pardis* (1994), 265 Mont. 470, 473, 878 P.2d 234, 235-36, *Butler v. Domin*, 2000 MT 312, P21 (Mont. 2000). *See also, Webb v. Board of Medical Examiners*, 202 Ariz. 555, 48 P.3d 505 (App. 2002) (holding that due process in an administrative licensing proceeding requires that both the standard of care and the deviation from that standard must be established in the record). The standard of care to which a board certified practitioner will be held is that skill and learning possessed by other doctors in good standing, practicing with the same national board certification. *Aasheim v. Humberger*, (1985), 215 Mont. 127 at 130, 695 P.2d 824 at 826.

5. Rule 702, M.R.Evid., provides that "if scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise." The party presenting a witness as an expert must establish, to the satisfaction of the trial court, that the witness possesses the requisite knowledge, skill, experience, training, or education to testify as to the diagnosis and treatment in question as to the standard of care applicable to the physician charged. *Glover v. Ballhagen* (1988), 232 Mont. 427, 756 P.2d 1166, 1168. Dr. Rohrer's testimony in this case is helpful to the trier of fact and establishes the standard of care that Dr. Allen had to meet in (1) deciding in the first instance to perform this operation on Arensmeyer, (2) in failing to discontinue the operation once underway due to the pervasive adhesions in Arensmeyer's abdomen, (3) in not properly assessing Arensmeyer's deteriorating

condition and (4) in not notifying Dr. Rohrer of Arensmeyer's condition prior to leaving for Shelby.

6. Dr. Rohrer was properly qualified as an expert in the field and his testimony on each of the above four areas demonstrates both the standard of care in this case and Allen's deviation from that standard of care. More simply stated, the facts of this case plainly show that this operation on Arensmeyer was contraindicated given Arensmeyer's complaints and physical condition. Upon discovering the pervasive adhesions, Dr. Allen should have stopped the operation. Dr. Allen also fell below the standard of care in failing to recognize Arensmeyer's deteriorating condition and failing to take Arensmeyer back to surgery to correct his bleeding. Finally, the facts plainly demonstrate that Allen's failure to personally contact Dr. Rohrer and advise Dr. Rohrer of Arensmeyer's condition so that proper care could be administered in Allen's absence fell far below the standard of care required of Dr. Allen. The department has thus demonstrated the standard of care required in this case and has also proven by a preponderance of the evidence that Dr. Allen fell below that standard of care. The violation of Montana Code Annotated § 37-1-316(18) has been preponderantly established.

7. Dr. Allen argues that his failure to personally contact Dr. Rohrer to advise about Arensmeyer's condition was excusable because of the on-call arrangement that Allen claims he and Rohrer had. This argument ignores the reality of the on call arrangement and further demonstrates an inexcusable lack of regard for an obviously deteriorating patient. Doctors Allen and Rohrer never automatically assumed coverage for the other doctor's patient. Moreover, if one of the doctors expected coverage from the other, that doctor would have personal contact with the other doctor to advise of a patient's condition. The on call arrangement between the doctors did not absolve either doctor of his professional responsibility to adequately inform the covering physician of a patient's condition and prognosis. Far from being excusable conduct, Dr. Allen's conduct shows that he basically abandoned a critically ill patient without making proper arrangements for that patient's care.

8. Dr. Allen also violated Administrative Rule 24.156.625(c) in telling David Arensmeyer and Barbara Mahn that Robert Arensmeyer had died of a heart attack and that there was no fresh blood in Robert's abdomen. Allen knew or should have known that Robert Arensmeyer did not succumb to a heart attack but rather died due to the post-operative bleeding. Dr. Allen had been specifically told by Nurse Toren (the nurse who attended Dr. Rohrer in his efforts to save Robert) that Robert had not had a "cardiac event." Allen's statement to the Arensmeyer children was deceitful in light of the knowledge that Allen had at the time of his conversation with the children and was almost certainly done to deflect attention away from Allen's malfeasance in this case.

9. Upon a finding that a licensee has committed unprofessional conduct, the regulatory board may impose any or all of a wide variety of sanctions including imposition of probation, restriction or limitation of practice, satisfactory completion of

a program of education or treatment, and compliance with conditions of probation for a designated period of time. Mont. Code Ann. § 37-1-312(c), (d) and (g). To determine which sanctions are appropriate, a regulatory board must first consider sanctions that are necessary to protect the public, and only after that determination has been made can the board then consider remedies designed to rehabilitate the licensee. Mont. Code Ann. § 37-1-312(2).

10. It is apparent from the facts of this case that Dr. Allen's failure to meet the professional standards of care required of him was the cause of Mr. Arensmeyer's death. The protection of the public, therefore, requires imposition of sanctions upon Dr. Allen including probation, monitoring of his practice, enrollment in the Montana Physicians Assistance Program (MPAP), and other restrictions upon his conduct.

IV. RECOMMENDED ORDER

Based upon the foregoing findings of fact and conclusions of law, the hearing examiner recommends to the Board of Medical Examiners that Dr. Allen's license be placed on probation for a period of five years with the following terms:

1. Within 60 days of the date of the final order in this matter, that Dr. Allen enter into a contract with MPAP for a period of three years from the date of the final order in this matter and successfully complete any required rehabilitation, treatment (including psychological testing and treatment) or other services prescribed by the MPAP program or required by the Board of Medical Examiners. The terms of the contract, and whether Dr. Allen has successfully completed any required rehabilitation, treatment, or other services prescribed by MPAP shall be subject to the approval of the Board of Medical Examiners.

2. The term of the MPAP contract and the term of his license probation shall be tolled (shall not run and shall not count toward the fulfilment of the MPAP requirement or the probation requirement of these recommended sanctions) during any time when Dr. Allen is not actively engaged in the practice of medicine.

3. Dr. Allen shall maintain a peer supervisor/mentor (who must be a general surgeon) who shall be approved by the Board of Medical Examiners. The peer supervisor/mentor's duties shall be approved by the Board of Medical Examiners. The peer supervisor/mentor shall be required to submit quarterly reports on Dr. Allen to the Board of Medical Examiners.

4. The Board of Medical Examiners or its designee may, in the sole discretion of the board, perform peer reviews on any of Dr. Allen's patient records. The cost of any such peer review shall be borne by Dr. Allen. In the event a peer review, in the sole discretion of the Board of Medical Examiners, demonstrates Dr. Allen's failure to provide appropriate care, Dr. Allen may be subject to summary suspension or any other sanction provided by law.

5. The Board of Medical Examiners or its designee shall be permitted to audit Dr. Allen's patient records with such frequency as the Board in its sole discretion deems appropriate.

6. Dr. Allen shall appear personally before the Board of Medical Directors with such frequency as directed by the Board.

7. Dr. Allen shall not conduct any surgery on any patient involving the peritoneum or pleura unless Dr. Allen stays in close proximity to the patient after the end of surgery for a minimum of 24 hours or such time as is reasonably medically necessary to ensure the proper care of the patient, whichever is longer, and shall arrange for

appropriate coverage for such patient thereafter. "Close proximity" shall mean that Dr. Allen must be able to be at the patient's side within 30 minutes after being paged or otherwise contacted about the patient. "Coverage" shall mean that Dr. Allen has personally notified the covering physician in advance, has explained the particular case to the covering physician, and has secured the covering physician's consent that the covering physician will undertake care of the patient in Dr. Allen's absence. Dr. Allen's post-surgical patient coverage for any patient must be documented on that patient's chart with written or dictated sign-out on that chart.

8. Dr. Allen shall obey all provisions of Montana Code Annotated Title 37, Chapters 1 and 3, and Montana Administrative Rules Title 24, Chapter 156.

9. In the event Dr. Allen fails to abide by any terms of this probation, his license shall be revoked.

DATED this 7th day of July, 2006.

DEPARTMENT OF LABOR & INDUSTRY
HEARINGS BUREAU

By: /s/ GREGORY L. HANCHETT
GREGORY L. HANCHETT
Hearing Examiner

NOTICE

Mont. Code Ann. § 2-4-621 provides that the proposed order in this matter, being adverse to the licensee, may not be made final by the regulatory board until this proposed order is served upon each of the parties and the party adversely affected by the proposed order is given an opportunity to file exceptions and present briefs and oral argument to the regulatory board.